Sun Life and Health Insurance Company (U.S.)

One Sun Life Executive Park, Wellesley Hills, MA 02481 800-247-6875

Group Enrollment form for Voluntary Group Term Life, Accidental Death and Dismemberment, Short-Term Disability Income, and Long-Term Disability Income Insurance

1 General information

Policyholder name		Account number	
PEF Membership Benefits Program		819927	
Street address	City	State	Zip code
10 Arline Drive, Suite 101	Albany	NY	12205
Type of activity: ☐ New Enrollment ☐ Change Reason:			

2 Member information

Member's Full Legal Name (First, MI, Last)			☐ Male ☐ Female	Date of Birth
Street Address	City	State	Zip Code	
Marital Status	Email Address	Phone number		
Member Status: ☐ Active Union ☐ Retired	Member ID #:	Social Security number		

You need to complete all sections of the enrollment form and sign it. This must be done either during the enrollment period or within 240 days of your eligibility date. PEF Membership Benefits Program will inform you which benefits are available. If after 240 days, please complete an online EOI, at www.mysunlifebenefits.com.

3 Benefit elections

Voluntary Life and Accidental Death & Dismemberment (AD&D) coverage:

If you select Spouse[1] / Partner or child(ren) coverage, you must complete section 4 of this form.

Member	☐ $20,000 ☐ 1X BAE ☐ 2X BAE ☐ 3X BAE ☐ 4X BAE ☐ 5X BAE **BAE = Basic Annual Earnings
Spouse[1] / Partner and Child(ren)	☐ $20,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 Child(ren): $15,000
Child(ren)	☐ $15,000

*Spouse[1] / Partner and Child(ren) may only be covered if Member is enrolling in, or already has a policy on themselves. Spouse[1] / Partner and Child(ren) are not eligible for Voluntary AD&D. Your Spouse[1] / Partner cannot elect more than 100% of your amount of Insurance for which you are eligible. Your Child(ren) cannot elect more than 100% of your amount of Insurance for which you are eligible or $25,000, whichever is less.

Disability coverage:

Member Short-Term Disability ..... ☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500 ☐ $600 ☐ $700

Member Long-Term Disability ..... ☐ 50% ☐ 60%

4 Dependent information

Please complete this entire section if you are selecting dependent coverage. You must complete this section if you elected coverage for your Spouse[1] / Partner and/or child(ren).

Relationship	Full Legal Name (First, MI, Last)	Gender	Social Security No.	Date of Birth
Spouse[1] / Partner			XXX-XX-	
Children			XXX-XX-	
			XXX-XX-	
			XXX-XX-	

☐ I understand Spousal[1] / Partner coverage is for married individuals or those who have executed domestic partnership forms on file with PEF Membership Benefits Program PEF Retirees Dental Program. If I have a change in my marital status, I must contact PEF Membership Benefits Program PEF Retirees Dental Program as soon as possible.

☐ I understand dependent children must be under the age of 19 years old or unmarried and under the age of 25 enrolled as a full-time student and who depends on me for 50% or more for his/her support. Not applicable to Life or Dental.

☐ For Life Insurance: I understand that dependent children must be dependent on me for support and maintenance and either under the age of 19 years old, or unmarried and under the age of 25 enrolled as a full-time student.

5 Beneficiary Designation information

Primary Beneficiary Designation

Voluntary Life and AD&D Insurance – On the lines below, list the individual(s) who should receive proceeds in the event of your death. You may specify as many individuals as you like, but the total proceeds must equal 100%. If you do not name a beneficiary or if no beneficiary is alive at the time of your death, proceeds will be payable in accordance with your Group insurance certificate.

			Percent share of proceeds
1 Name (First, M.I., Last)	Relationship to Member	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to Member	Social Security number	%
Address	Phone number	Date of birth	
3 Name (First, M.I., Last)	Relationship to Member	Social Security number	%
Address	Phone number	Date of birth	

5 **Beneficiary Designation information,** continued

Secondary Beneficiary Designation

Voluntary Life and AD&D Insurance – On the lines below, list the individual(s) who should receive the proceeds ONLY IF ALL of the individuals listed above as your primary beneficiary(ies) are not living at the time of your death. This is your secondary (or contingent) beneficiary. The secondary (or contingent) beneficiary is not paid if your primary beneficiary is alive at the time of your death.

			Percent share of proceeds
1 Name (First, M.I., Last)	Relationship to Member	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to Member	Social Security number	%
Address	Phone number	Date of birth	
3 Name (First, M.I., Last)	Relationship to Member	Social Security number	%
Address	Phone number	Date of birth	

6 **Evidence of insurability and authorization information**

A medical Evidence of Insurability ("EOI") application will be required for any Member and/or dependent who applies for coverage more than 240 days past his/her eligibility date. An EOI application is also needed if you:

- apply for a higher coverage than the Maximum Guaranteed Issue amount during an open enrollment period
- want to increase your existing coverage now or at a later date, Whether your existing coverage is with Sun Life and Health Insurance Company (U.S.) or a prior insurance carrier
- decline coverage and then want it at a later date

Coverage subject to evidence of insurability will not go into effect until Sun Life and Health Insurance Company (U.S.) approves it.

Websites to complete online EOI: www.mysunlifebenefits.com.

6 **Evidence of insurability and authorization information,** continued

I understand that:

- I am requesting coverage under a Group Insurance policy.
- My policyholder will deduct all or part of the premium for contributory coverage from my pay, pension, EFT, or Direct Billing through invoice.
- If I decline coverage for myself or, if applicable, for my family now and want it at a later date, I/we will have to submit an Evidence of Insurability application which is acceptable to Sun Life and Health Insurance Company (U.S.). I have read the Evidence of Insurability notice.
- **Accelerated Benefits:** Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. If you have received an accelerated benefit, your life insurance will be reduced by an amount equal to the accelerated benefit paid by Sun Life and Health Insurance Company (U.S.).
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- When required by the coverage, if my spouse or any of my dependent children are confined due to an injury or illness, as required by the coverage, on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer confined. Confined means confined to a hospital or similar facility, or confined at home due to an illness or injury and under the care of a Physician.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief. I have read or had read to me the fraud warning for my state.

<u>Does not apply to Life Insurance.</u> Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

X _____ _____

Member Signature Today's Date

To the Member: Make a copy of this form for your records before submitting it to:

PEF Membership Benefits Program
10 Airline Drive, Suite 101
Albany, NY 12205

(518) 785-1900, ext. 243 or (800) 342-4306, ext. 243
mbinsurance@pef.org

This original enrollment form should remain at Your Policyholder's site. Family status, coverage, or beneficiary changes should be recorded on another copy of the Enrollment form.

[1] You must be legally married to enroll someone as a spouse.

Contact us

By mail:
PEF Membership Benefits Program
10 Airline Drive, Suite 101
Albany, NY 12205

www.PEFmbp.com

Sun Life Customer Service
1-855-697-7336
M–F 8:00 a.m. – 8:00 p.m., ET